SCHEDULE A-1 Tax ID #: **FACILITY NAME:** Multiple Sites 1 - 6 1. Name of Facility: 4. Medicaid Provider Number: 5. Name of Contact Person/Director/Administrator: Street: 6. Licensed Bed Capacity for THIS FACILITY: City, State, Zip Code: 2. Telephone No.: 7. Resident or Occupied Days: 3. E-Mail (if available): 8. Level of Care 1. Name of Facility: 4. Medicaid Provider Number: Name of Contact Person/Director/Administrator: Street: City, State, Zip Code: 6. Licensed Bed Capacity for THIS FACILITY: 2. Telephone No.: 7. Resident or Occupied Days: 3. E-Mail (if available) : 8. Level of Care 1. Name of Facility: Medicaid Provider Number: Name of Contact Person/Director/Administrator: Street: City, State, Zip Code: 6. Licensed Bed Capacity for THIS FACILITY: 2. Telephone No.: 7. Resident or Occupied Days: 3. E-Mail (if available) : 8. Level of Care 1. Name of Facility: 4. Medicaid Provider Number: Name of Contact Person/Director/Administrator: Street: City, State, Zip Code: Licensed Bed Capacity for THIS FACILITY: 2. Telephone No.: 7. Resident or Occupied Days: 3. E-Mail (if available): 8. Level of Care Name of Facility: 4. Medicaid Provider Number: Street: Name of Contact Person/Director/Administrator: City, State, Zip Code: 6. Licensed Bed Capacity for THIS FACILITY: 2. Telephone No.: 7. Resident or Occupied Days: 3. E-Mail (if available) : 8. Level of Care 1. Name of Facility: 4. Medicaid Provider Number: Name of Contact Person/Director/Administrator: Street: 6. Licensed Bed Capacity for THIS FACILITY: City, State, Zip Code: 2. Telephone No.: 7. Resident or Occupied Days: 3. E-Mail (if available): 8. Level of Care

MULTIPLE SITES - 2006 RESIDENTIAL TREATMENT COST REPORT

DMA-RATE SETTING September 21, 2005